Texoma Community Center

QUALITY MANAGEMENT PLAN

Fiscal Years 2014-2015

I. Overview

The Quality Management Plan provides Texoma Community Center (TCC) with a systematic, objective and continuous process for monitoring, evaluating and improving the quality and appropriateness of the service delivery systems within our organization. It assists TCC in assuring existing standards of care are met and provides the framework to obtain feedback from stakeholders on the manner in which the center conducts business.

The Quality Management plan is an evolving document continuously revised to reflect changes within the Center as they occur. This allows us to make updates to the plan based on input from individuals whom we serve, their family members, our employees and contractors, and other stakeholders in the community. The plan is refined based on information developed from the resources and requirements of the Texas Department of Aging and Disability Services (DADS) and the Texas Department of State Health Services (DSHS).

The overall intent of the center's QM activities is as follows:

- to recognize opportunities to improve quality of service and to assist the center to capitalize on these opportunities
- to assist staff to achieve/maintain excellence in service provision
- to understand and report on the utilization of resources
- to obtain and analyze feedback from stakeholders to improve quality of services
- to evaluate the center's success in accomplishing the mission, vision and values
- to use results of QM activities to assist the center in developing future goals and objectives

Below are the methods by which the center's QM Department intends to measure whether these outcomes are achieved.

To recognize opportunities to improve quality of service and to assist the center to capitalize on these opportunities:

a) As evidenced by QM Reports that program and leadership staff views as clear, concise, and meaningful.
b) As evidenced by QM Reports that are distributed and communicated as indicated in **Exhibit D.**

To assist staff to achieve/maintain excellence in service provision:
(See a. Above.)

c) As evidenced by QM staff participation in training and staff development activities as requested or recommended.

To understand and report on the utilization of resources:

d) As evidenced by the development, identification and use of meaningful utilization reports in resource utilization decision-making.

e) As evidenced by early identification of over-utilization or inappropriate utilization.

To obtain and analyze feedback from stakeholders to improve quality of services:

f) As evidenced by the use of feedback in center planning and decision-making regarding quality improvement activities.

To evaluate the center's success in accomplishing its mission, vision and values:

g) As evidenced by the identification of measures related to mission, vision and values, which are monitored by the AMT and Quality Improvement teams.

To use results of QM activities to assist the center in developing future goals and objectives:

(See a. and b. above.)

h) As evidenced by the use of QM findings in center planning and decision-making regarding future goals and objectives.

Planning for quality begins with the adoption of a Mission and Vision that directs the organization to continually improve services, as defined by individuals served, families and the community, within the organization. The Board of Trustees (BOT) for TCC has adopted a Mission for accountability to these stakeholders for utilization of resources in a cost efficient manner with processes for changing the system to meet their needs.

An integral part of planning for quality begins with local planning to set the direction for quality planning for the organization with expected identified outcomes. Long range planning takes place within the organization with input from all stakeholders at the direction of the Board of Trustees. As the Local Authority for Mental Health and Intellectual and Developmental Disability (IDD) Services for the tri-county area, the center is responsible for long range planning, resource allocation, obtaining the best value in service delivery, service appeals, and grievance processes, protection of rights, business functions and accounting, network development and management and assuring quality of life for individuals served. Planning occurs through the following:

- Self-assessment processes
- Planning and Network Advisory Committee (PNAC) Initiatives
- Advisory Groups
- Management initiatives

II. Authority, Leadership and Delegation of Responsibility

The development and implementation of a Quality Management Program is a required element indicated in the Performance Contract between the Department of Aging and Disability Services (DADS) and TCC and Department of State Health Services (DSHS) and TCC. The Quality Management Program derives its authority from the Executive Director who is supervised by the governing body, the Board of Trustees. The Executive Director delegates the responsibility for the development, implementation, monitoring and evaluation of the QM Program to the Director of Quality Management with oversight by the Quality Management Committees. The role of the QM Committees is to ensure implementation and integration of the various components of the QM Program. These committees are comprised of executive management, program Directors and other stakeholders to act upon the recommendations by QM staff and standing committees.

The Executive Director approves the Quality Management plan in writing. The Quality Management Department operates under the direction of the Quality Management Director who is supervised by the Chief of Operations.

III. Defining Quality

In the Quality Management Program at TCC, quality for the organization is represented as a set of standards and expectations in the form of targets, objectives and outcomes.

By performing Quality Management activities, we are assuring:

- individuals served are receiving the services they need
- individuals served are satisfied
- services are efficient and accessible
- services fulfill the requirements of the Performance Contract with the Department of State Health Services (DSHS) and the Department of Aging and Disability Services (DADS)

Quality Management is conducted at TCC to assure compliance with laws and regulations, to provide objective data to manage the organization and to assure viability of the organization. Quality Management also defines the ongoing self-assessment processes for developing recommendations for improvement.

IV. Mission, Vision and Value Statements for Texoma Community Center

The Quality Management Plan is driven by, and supports, the vision and mission of TCC. These areas are defined below:

MISSION

The mission of the Center is to provide services that improve quality of life and support self-determination for persons with mental, intellectual, and developmental challenges.

VISION

Texoma Community Center looks to a future when persons with mental and developmental challenges are fully integrated and vital members of the community.

To achieve this vision, the center is committed to:

- ♦ Engaging in individual service activities that demonstrate regard for personal choice while maximizing each individual's potential;
- ♦ Promoting a network of providers that demonstrate effective quality service outcomes for individuals served and effective cost management for the Center;
- ♦ Providing community education and outreach that focuses on eliminating stigma and demonstrates the capabilities of persons with mental, intellectual, and developmental challenges;

- Facilitating fulfilling lifestyles for individuals served;
- Promoting the development of services that support physical and emotional well-being;
- Advocating for personal development and recovery as a model of care;

VALUES:

- **Individual Worth**: we affirm that the individuals we serve share with us common human needs, rights, desires, and strengths. We celebrate our diversity and individual uniqueness.
- **Quality**: We are committed to achieving excellence and continued growth throughout the Center to meet community needs.
- **Integrity:** We are dedicated to enhancing service delivery and optimizing revenue sources with professionalism and honesty.
- **Dedication**: We are committed to serve the public and to advocate for the individuals we serve.
- **Innovation:** We are committed to developing innovative staff support systems that promote excellence in performance.
- **Teamwork**: We believe that our responsibilities are exemplified by partnerships among the Center, its staff, and the community we serve
- **Adaptability**: We are committed to flexibility as changes occur while maintaining our unique role in meeting the community's needs.

The Mission, Vision and Value Statements are written with input from all levels of the organization. Training on the Mission, Vision and Values begins with new employee orientation and permeates throughout the organization on a continuous basis. Upon the direction of the Board of Trustees, the Mission, Vision, and Values are reviewed with input from employees, individuals served, families and other stakeholders.

V. Services:

TCC provides the following array of services:

A. **Adults with Mental Illness**: Crisis Hotline, crisis services, screenings, pre-admission assessments, Case Management, and treatment planning. TCC assures the following services are provided: respite, medication administration, medication monitoring, pharmacological management, provision of medication, individual and group training such as medication training and supports and skills training and development, counseling, psychosocial rehabilitative services, supported employment, supported

housing and inpatient services. Outreach, screening, assessment, referral for Substance Abuse services, participation in Community Resource Coordination Groups (CRCG) and Jail Diversion are also provided.

B. **Children with Mental Illness**: Crisis Hotline, crisis services, screenings, pre-admission assessments, Case Management, and treatment planning. TCC assures the following services are provided: respite, medication administration, medication monitoring, pharmacological management, provision of medication training and supports, skills training and development, counseling, participation in CRCG and family partner support.

C. **Individuals with Intellectual/Developmental Disabilities or Related Conditions:** Eligibility determination and Service Coordination (basic Service Coordination, HCS case management, continuity of services for state facilities, continuity of services for Medicaid programs and service authorization and monitoring). TCC assures the following services are provided: respite, supported employment (employment assistance and individualized competitive employment), day habilitation training services, supported home living, permanency planning, participation in CRCG, and residential services.

VI. Coordination of Services

To ensure the coordination of services, within the local service area - with other agencies, including other health and human service agencies, criminal justice entities, Substance Abuse Community Coalition Programs, Prevention Resource Centers, Outreach Screening Assessment and Referral organizations, other child-serving agencies (e.g., Texas Education Agency (TEA), Department of Family and Protective Services (DFPS), Texas Youth Commission (TYC), family advocacy organizations, local businesses, and community organizations. In accordance with applicable rules, ensure that services are coordinated among network providers and between network providers and other persons necessary to establish and maintain continuity of services while ensuring choice among all eligible network providers, including compliance with the following items:

A. Comply with the memorandum of understanding (MOU) (at 40 TAC Chapter 72, Subchapter M) relating to continuity of care for offenders with mental impairments, required by THSC §614.013, and notify the Texas Correctional Office on Offenders with Medical or Mental Impairments if there is a change in primary or alternate staff members responsible for the functions of the MRA set forth in that MOU
B. Provide continuity of care for offenders with mental impairments, as required by Texas Health & Safety Code §614.013 and §614.017 by assisting Community Supervision and Corrections Department personnel with the coordination of supervision for offenders who are individuals served by the Center
C. Provide services to persons referred by the Texas Youth Commission, pursuant to Title 37, TAC, Chapter 87, Subchapter B, Special Needs Offender Programs, §87.79, Discharge of Mentally Ill and Mentally Retarded Youth.
D. Participate in the established Community Resource Coordination Group (CRCG) for children, youth, and adults, by providing one or more representatives to each group with authority and expertise in mental health and IDD services, as appropriate, who have the authority to contribute resources toward resolving problems of persons needing agency services identified by the CRCG. In accordance with the MOU required by the Texas Government Code (TGC) §531.055 regarding the Memorandum of Understanding for Coordinated Services to Persons Needing Services from More than one Agency.

E. Notification to the CRCG in the county of residence of the parent or guardian of a person younger than 22 years of age with a developmental disability when placed by the MRA in a group home or other residential facility, as required by TGC §531.154(a)(3)
F. Cooperate with the Texas Education Agency (TEA) in the individual transition planning for children and adult individuals served receiving special education services, in accordance with 34 CFR §300.344, IEP Team, 34 CFR §300.347, Content of IEP, and 34 CFR §300.348, Agency Responsible for Transition Services.
G. Establish and maintain a continuum of care for children transitioning from the Early Childhood Intervention (ECI) program into children's mental health services.

VII. Structure and Functions

A. The functions of the Quality Management Department include assimilating data and information from Utilization Review, Quality Assurance functions, and internal/external audits and reviews. The department is responsible for reporting those findings to the Administrative Management Team (AMT) as they take place and making recommendations for system improvement.

B. Quality Management Department personnel participate in the establishment of center goals and support the center to achieve its stated goals by working collaboratively with staff and by guiding and supporting quality improvement efforts. The purpose of the Quality Management (QM) Plan is to describe a systematic approach for providing this support.

C. Quality Management Program activities for TCC are coordinated by the Quality Management Department. The Department includes the Managed Care Specialist, Staff Training Specialist, Data Management Coordinator, Quality Management/Contracts Specialist, the Rights Protection/QM Specialist, Data Management Specialist and the Director of Quality Management. The Director of IDD Services, the Director for Mental Health Services, Chief Operations Officer and support staff also participate in some quality management activities. (See Exhibit "E" for organizational chart). The Quality Management Department provides the common thread amongst all of the committees in the center and assures that information is reviewed by the AMT.

D. Many of the functions related to quality and utilization management are reviewed on a daily basis by the Director of Mental Health Services, Director of IDD Services, the Director of Early Childhood Intervention Services, and by others as directed by management staff. This information is regularly reported to and reviewed by the Quality Management Department. Utilization and performance data is reviewed at the local level by Program Directors and at the Center level by the Quality Management Committees and the Utilization Management Committee, which includes at least two members of the AMT.

E. The Quality Management Program of TCC provides the structure for the center to:

- evaluate the efficiency of the organization's functioning
- evaluate services provided by TCC
- set goals and objectives for the organization to continue to improve services ensure compliance with all laws, rules, policies and procedures for service implementation and billing
- conduct self -assessment activities
- conduct planning activities

- assure compliance with Texas Resiliency and Recovery (TRR) by assuring services are ongoing, match the needs of the individual, are focused on recovery, and guided by evidence-based protocols and a strength-based model of service

This is accomplished with input and information from the following committees:

F. Committees

1. Utilization Management: Key components of the Utilization Management committee include measuring, assessing and improving service capacity and access to services. The Utilization Management Committee meets quarterly. The primary function of the UM Committee is to monitor utilization of TCC's clinical resources to assist in the promotion, maintenance and availability of quality care in conjunction with effective and efficient utilization of resources. The objectives of the UM Committee includes processes to:

a. Assure the overall integrity of the utilization management process to include timely and appropriate assignment of DSHS Mental Health levels of care based on the DSHS UM Guidelines;
b. Approve and oversee the appeal system for adverse determination decisions to assure fairness and equity;
c. Analyze use of exceptions and overrides to service authorization ensuring rationale is clinically appropriate and documented in the administrative and clinical record
d. Analyze utilization patterns and trends within TCC, to include gaps in services, rates of no shows for appointments/services, billing issues, frequently requested services, existing services that are under and over-utilized, and barriers to access;
e. Establish mechanisms to report quantitative and qualitative information on service utilization and service delivery to TCC's management and staff, the Board, providers and other interested persons on a timely basis.
f. Request for Services: monitors access to services by monitoring appeals of termination, reduction and denial of services. All appeals are reported at least quarterly to the Quality Improvement Committees and subsequently to the Administrative Management Team.
g. Evaluate the cost-effectiveness of all services provided.

(*See Exhibit "F" for the UM Program Plan)

2. Quality Improvement Committees: There are two Quality Improvement (QI) committees within TCC; one for Mental Health services and one for IDD services. These committees are charged with reviewing, approving and assisting with the development of the Quality Management Program to ensure quality services for the individuals whom we serve and to ensure that services are provided in the most efficient manner. These committees meet at least quarterly, and frequently, more often. Membership for the IDD QI committee is composed of the Director of IDD Services, the Assistant Director for IDD Services, the Coordinator for IDD Provider Services, the Residential Coordinator, the Quality Management Director, Rights Protection Officer, a QIDP, two R. N.'s for Provider Services and Community Support staff.

Membership for the **MH QI** Team, also known as the Mental Health Action Team, is composed of the Director of Mental Health Services, the Assistant Director of Mental Health Services, the Chief Operations Officer, the Data Management Coordinator, the Quality Management Director, Rights Protection Officer, the Nursing Supervisor for mental health services, The Managed Care Specialist, the Data Specialist, Training Coordinator and the MH Clerical Support Supervisor.

3. Planning and Network Advisory Committee (PNAC): The role of this committee is to ensure that local stakeholders have direct input and involvement in assessing and determining the mental health and IDD service needs of individuals served. This is accomplished through identifying the most important needs in the community, evaluation of cultural and ethnic issues and assessing progress towards implementation of the Local Plan. They must also oversee the objectivity in the procurement of services and the definition of best value in public mental health and IDD services. They review processes and make recommendations to the Board of Trustees as to whether management has been fair and objective in reviewing services.

The PNAC is comprised of between five and nine members representative of people with mental illness and IDD, local practitioners, and other interested members of our community. To ensure equal representation of individuals with both Mental Illness and IDD, the committee includes a consumer with IDD, a family member of a consumer with IDD, a consumer with Mental Illness and a family member of a consumer with Mental Illness. The purpose of the committee is to advise the Board of Trustees on planning, contract issues, needs and priorities for the service area and for TCC. Activities include review of surveys, needs assessments, assistance in development of goals and objectives in the Local Planning process for TCC and monitoring implementation of goals and objectives.

4. Safety/Infectious Disease Committee: The role of this committee is to oversee health and safety related issues of individuals served and employees. Their purpose is to review established procedures and requirements for the prevention of accidents and make recommendations for needed changes, as necessary. This is accomplished through regular meetings and the analysis of data related to incidents/injuries, vehicle accidents, medical incidents (including illness), hospitalizations and infectious diseases of both employees and individuals served. Membership consists of the Safety Coordinator and representatives from MH, IDD, and Early Childhood Intervention services in all three counties including direct care, management and support services staff. Meetings are held quarterly and any identified areas of concern are outlined and provided to the AMT and other leadership staff.

5. Consumer Advisory and Human Rights Committee: The role of this committee is to review allegations of consumer rights violations and complaints and to review data to look for trends within HCS and TxHmL waiver programs, as well as IDD General Revenue Services, as requested. They assure that persons served within these programs are provided services and treatments in the least intrusive manner appropriate to the individual's needs, that they are afforded due process and that their rights are fully protected. The committee also must review all rights restrictions within the HCS and TxHmL programs, at least annually.

Activities include promotion of policies and procedures to protect the rights of the people served and to assure the procedures are in compliance with all rules and regulations set forth by law and the performance contract. Membership consists of the Residential Coordinator, Rights Protection Officer (RPO), family members, a non-affiliated community representative, and a consumer within one of the waiver programs. The Director of IDD Services serves as an ex-officio member. Meetings are held at least quarterly, and as needed, and information is reviewed by the AMT and IDD Quality Improvement team. This team also serves to review rights related issues for individuals receiving General Revenue services which either the Rights Protection Officer or IDDIDD Authority staff feels needs additional input and oversight.

6. Specially Constituted Committee: The role of this committee is to review allegations of consumer rights violations and complaints and review data to look for trends within the ICF-IDD program. Also, they must review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to individual protection of rights. They must assure that persons served within this program are provided services and treatments in the least intrusive manner appropriate to the individual's needs, that they are afforded due process and that their rights are fully protected. The committee also must review all rights restrictions at least annually. Activities include promotion of policies and procedures to protect the rights of the people served and to assure the procedures are in compliance with all rules and regulations set forth by law and the performance contract. Membership consists of the Rights Protection Officer, family members and guardians, a non-affiliated community representative, center employees and individuals served living within the facilities, as appropriate. The Director of IDD Services serves as an ex-officio member. Meetings are held as needed, but at least annually. Information is reviewed by the AMT and IDD Quality Improvement team.

7. Clinical Records Committee: The role of this committee is to ensure forms review, clinical records reviews, developing a standardized record system and determining the elements to be included in the official consumer record. Membership consists of the Clinical Records Administrator, representation from Mental Health programs and representation from IDD programs. Disciplines not represented on the committee are consulted as needed. The committee meets on at least a quarterly basis.

8. Professional Review Committee: provides a mechanism for clinical review of high risk events and oversight for issues related to the quality and appropriateness of services. Meetings are held as needed and topics may include, but are not limited to the following: critical incident reviews, performance profiling/evaluation, credentialing and re-appointment reviews and Clinical Policy Development. The purpose of the Professional Review Committee is to provide a forum supporting the discussion of medical care provided by TCC and to conduct professional review of medical and healthcare services to improve the quality of care pursuant to the Texas Revised Civil Statute Article 4495b and the Texas Health and Safety Code article 161.031-161.033 which provide a privilege of confidentiality for professional review activities in the State of Texas. The Committee will oversee and ensure the delivery of quality care to the individuals served by TCC.

9. **Death Review Committee**: The center's Death Review Committee, chaired by the Medical Director, will conduct reviews of deaths that meet guidelines set forth by the state. Other members of the committee include an R. N., Executive Director, QM Director and a non-affiliated community member. The purpose of the review committee is to identify any areas of concern surrounding the death of a person served and to make recommendations for system improvement.

Please see Exhibit "D" for further detail of committees involved in Quality Management Activities.

VII. Monitoring, Evaluation, Tracking and Trending = Improvement

QM processes involve a cycle of communication and activity that is directed toward learning and improvement. As services are provided, documentation of those services occurs and data is collected about those services. Individuals served and other stakeholders are also invited to provide input regarding their experiences with service provision. The data regarding service provision is compiled and analyzed and teams and relevant staff are informed of the findings and conclusions of this analysis. Areas for improvement are targeted and plans developed. The plans are implemented and monitoring occurs to check progress. Service provision is modified as needed to achieve improvement or correction as necessary.

Examples of collected measurement data include:

A. Input-Information solicited from the following:

- Performance Contract Measures
- External Data Reports such as MBOW, CMBHS and CARE Reports
- DSHS and DADS Consultations
- Internal Data and Software Reports such as service data, assessment data and budget reports
- Internal/External audits, feedback and action plans, and follow-up monitoring
- Internal Management Reports including Incidents and Medication Error reports, Critical Incident Reporting System, Regulatory agency reviews and findings
- Interviews of both individuals served and staff regarding complaints and investigations
- Meeting minutes from internal committees, interagency groups and task-oriented work groups
- Observations of the environment and processes
- Satisfaction Survey Reports from individuals served, family members and advocates
- Strategic plan including the Center's Vision, Mission and goals

B. Data Collection – Data is collected from the following:

- Advocacy Groups, Appeals, Service Complaints, and Rights Issues
- Billing audit reviews
- Community Relations
- Credentialing and Re-Credentialing Data
- Fiscal Information
- Internal and External Committees

- State Authority, Oversight Agencies and other Payer sources
- Mental Health Self- Assessment Results
- Strategic Planning Process
- Information Management Systems
- Medical Records
- Quality Management Audits
- Utilization Management including Provider profiling data, Service Evaluation data, Utilization data and Review

TCC measures, analyzes and improves the accuracy of data reported through the use of i-Serv (internal software program), Web CARE and through Business Objects in the following manner:

C. i-Serv data is retrieved to achieve the following:

- Ensure timely entry of data
- Monitor status of services
- Monitor staff productivity
- Access form Tracker
- Monitor pivot data
- Monitor waiting List, as applicable

D. CMBHS is utilized to monitor:

- Authorizations
- Appropriateness of service packages
- Discharges

E. MBOW data base is utilized in assessing:

- Data Quality
- CA Financial
- Utilization Management
- Contract Performance Measures
- Encounter Exceptions
- IDD Financial
- IDD Performance Oversight

F. Measurable Objective Indicators

REQUIREMENT	**Q1-2**	**Q3-Q4**
ADULTS	**TARGET**	**TARGET**
Number Served (6 mo.) (100%)	763	763
UA Completion Rate (6 mo)	95%	95%
LOC-1S - Avg Hours (6 mo)	1.3 hours	1.3 hours
LOC- 2 - Avg Hours (6 mo)	3.25 hours	3.25 hours
LOC- 3 - Avg Hours (6 mo)	5.87 hours	5.87 hours
LOC- 4 - Avg Hours (6 mo)	10 hours	10 hours
ACT Average hours 6 mo (100%)	10.0	10.0
Supported Employment Target (annual)	3%	3%
Supported Housing Target (annual)	3%	3%

Counseling Target *(Rec Loc 2)*	>=12%	>=12%
ACT Services Target *(Rec loc 4 in 3 or 4)*	>=54%	>=54%
Intensive Ongoing client count Adult	18	18
Employment	>=8.6%	>=9.8%
Housing	>=95.8%	>=96.6%
Community Tenure	>=97.8%	>=96.4%
Improvement	>=15.0%	>=20%
Engagement	>=50.8%	>=54.1%
CRISIS OUTCOMES		
Hospitalization	<=1.3%	< =1.9%
Jail Diversion	<=22.2%	<=19.3%
Effective Crisis Response	>=69.9%	>=75.1%
Frequent Admissions	<=.5%	<=.3%
Access to Crisis Response Svcs	>=36.4	>=52.2%
TANF Transfer to Title XX Services	3	3
NGM Target (100%)	94	94
Individuals d/c with comm sppt plan	95%	95%
Readmissions: (>=q1=5%; q2=10%)		
Follow-up w/in 7 days (face to face)	>= 75%	>= 75%
Follow-up disposition (any)	>= 95%	>= 95%
Crisis Episode Resulting in psych hosp	<=22%	<=22%
Community Linkage	>=23%	>=23%
Crisis Follow-up	>=90%	>=90%
Transitional Services (LOC 5)	14	14
CHILD AND ADOLESCENT ONLY	**TARGET**	**TARGET**
Number Served	138	138
UA Completion Rate	95%	95%
LOC- 1	.5 hours	.5 hours
LOC- 2	3 hours	3 hours
LOC- 3	5 hours	5 hours
LOC- 4	7.5 hours	7.5 hours
LOC- YC	3.5 hours	3.5 hours
Family Partner Supports LOC-4	80%	80%
Family Partner Supports (LOC 2, 3, YC)	10%	10%
Juvenile Justice Avoidance	95%	95%
Community Tenure	>=98.8%	>=98.1%
Improvement Measure	>=15%	>=25%
Engagement Measure	>=69.9%	>=77.8%
Intensive On-going Services	1	1

Any of the above areas that may fall outside the parameters as set forth in the Performance Contract are reviewed by the Quality Management teams to determine what action is needed.

VIII. Patterns for Assessing, Evaluating, Monitoring, and Trending Data

A. Annually:

1. Self-Assessments: Center services are assessed in an ongoing manner using satisfaction surveys, clinical reviews, records reviews, and other monitoring methods. At least annually, results of these assessments are shared with the AMT and quality improvement teams; quality indicators are identified and improvement goals written that are consistent with the center's mission, goals and objectives, as stated in the Local and Operational Plan. The quality indicators and improvement goals may relate to clinical areas, to non-clinical areas, or to organizational processes. Each action step or monitoring activity is assigned to an individual or team, who has responsibility for implementing and reporting on that item back to the team.

2. Satisfaction Surveys: The QM Department distributes satisfaction surveys at least annually for both MH and IDD program areas. Results of all surveys are shared with the AMT, relevant Program Directors, quality improvement teams and the PNAC, and are used to identify areas needing improvement. In addition to these internal surveys, the QM Department assists in the distribution of the DSHS Adult and Children's Mental Health Satisfaction Surveys on an annual basis as requested by DSHS.

3. Needs Assessments: The QM Department conducts surveys to assess consumer and community needs at least annually. Surveys are distributed to people served, their families, and key persons in the community. Results are shared with the AMT, the center's Planning and Network Advisory Committee (PNAC), and the quality improvement teams.

4. Contract Monitoring: The center contracts with a variety of sources for consumer services. Center procedures require that the staff member assigned as liaison with each contractor complete an annual monitoring tool (developed by the QM Department). The tool is returned to the QM Department for review and analysis. Problems or concerns are addressed with the relevant Program Director or AMT member as appropriate. All contracts are reviewed annually for compliance with contract requirements.

5. Ongoing Fidelity Assessment: The center will conduct ongoing assessments to monitor the fidelity to TRR service models; will conduct regular rapid reviews to evaluate maintenance of fidelity, and ongoing reviews which will be conducted by joint DSHS and LMHA fidelity review teams.

6. Plan to Reduce Abuse and Neglect: The Center will review and revise the Plan to Reduce Abuse and Neglect on an annual basis. We base this review on reports of trended data from abuse and neglect reviews as well as input from the Administrative Management Team, Safety Committee, SCC and Consumer Advisory/Human Rights committees. This plan contains initiatives by the Quality Management department with support and endorsement by program staff and other departments. The current plan is included as Exhibit C.

7. Emergency Plan: The Center shall have an emergency plan that addresses specific types of emergencies and disasters that pertain to the area of the state in which the Center is located, including natural disasters, fire, equipment failure, a pandemic and terrorism. The Center will ensure that the staff at program sites is knowledgeable of the emergency plans and that staff and individuals served follow the plans during drills and real emergencies.

8. Interest List Maintenance: Center MRA staff ensures that individuals placed on the Interest List are contacted on at least an annual basis and their preferred services and supports are updated.

B. Quarterly:

1. Quality Improvement Monitoring: The two quality improvement teams review progress on accomplishment of action steps in their plans. They evaluate whether the action steps identified in the plan are effective in making progress toward the desired outcomes and make modifications as needed. They identify what additional information is needed to measure progress and what steps are needed to encourage progress and improvement. Quality Improvement teams have switched their focus to an “Action Team” approach that moves in and addresses specifically identified problems rather than only standing agenda items. This approach, at times, requires more frequent meetings.

2. Monitoring of Performance Contract Targets: The Program Directors and Business Services review data related to compliance with State Performance contracts targets, and communicate the results of the review with the AMT and relevant Program Directors. The MH Action Team reviews Performance Contract Targets on a weekly basis. Corrections and adjustments in service activities are made as needed.

C. Monthly:

1. Credentialing: At least monthly, or as needed, QM Department personnel ensure that a copy of the current license for all licensed employees and contractors is on file with personnel or with the contract, as appropriate. In addition, the credentialing process for staff and contractors will include insuring there is documentation on file that the person has received training in the area of COPSD, in compliance with TAC 411, N.

2. Summary of Critical Data: Monthly, the QM department staff summarizes the center’s critical data related to rights, abuse, health, and safety and distributes this information to the AMT, who then distributes it to the BOT. At least quarterly, the information is also reviewed by the quality improvement teams as needed. This data includes an analysis of complaints, safety incidents, and occurrence of infectious disease. It also includes an assurance that all safety inspections - fire marshal and health department inspections - have been conducted as required. Trends or significant changes in data are investigated. **Exhibit B** includes a description of how critical data will be collected for FY 2014-2015.

3. Internal Program Monitoring: Program Directors review CARE and i-Serv data related to staff productivity and benchmarking, as applicable, and also monitor cost of services through budget reports at least monthly. Program Directors conduct records reviews to monitor compliance with critical regulations or standards. This information is

used to assist the program Director in guiding the unit toward greater compliance and improved quality of care. Issues identified through this monitoring may be forwarded to the quality improvement teams for assistance in addressing.

4. Waiting List Monitoring: The Center will comply with the DSHS and DADS Waiting List Maintenance requirements for all individuals who have requested mental health or IDD services and the Center anticipate the services will not be available upon request. The individual will be monitored in accordance with the DSHS and DADS frequency requirements to determine continued need. Currently, the Center does not have a waiting list for services.

D. Ongoing:

1. Resolution of Service Complaints and Rights Issues: The RPO directly receives service complaints and alleged rights violation reports. The RPO ensures that all information is gathered from the person, family member, staff member, or concerned citizen and follows up as warranted with appropriate individuals. The RPO ensures that the issue is dealt with in a fair and equitable manner.
2. Corporate Compliance: The Center is committed to following State and Federal guidelines and regulations regarding insurance billing and cost reporting. In that accord, the Center maintains a Corporate Compliance Plan and Business Code of Conduct to assure its activities are in compliance with those regulations. This plan is supported by all levels of employees and the Board of Trustees.

3. Monitoring of Crisis Services: For monitoring purposes, each crisis note is reviewed to determine if the response timeframes, (i.e. e., emergent, urgent, routine) have been met as set forth in the Mental Health Community Standards. Each crisis note is reviewed for content and appropriate response to determine if additional staff training is needed. The information is reviewed with the crisis team at weekly meetings.

4. The Medical Director oversight includes several components:

- On a quarterly basis, the Medical Director reviews the total General Revenue (GR) disbursements related to medication expense, within the usual committee structure during regularly scheduled meetings.

- On a regular basis, under the auspices of the Director of Quality Management, selected charts are audited for completion related to medication documentation including informed consent documents and routine laboratory orders pertinent to the particular medication(s).

- Approximately quarterly, the Medical Director evaluates the prescribing practices of New Generation Medications (NGMs) by obtaining the data in the CARE system. In particular, the rates of NGM poly-pharmacy are checked against a benchmark that has the total number of patients prescribed two concurrent NGMs, less than or equal to 10%.

- Irregularities or problem trends that come to the attention of the Medical Director through these or other means will be discussed in follow up at the next regularly scheduled medical staff meetings as needed.

- The Medical Director will identify and review the chart of any patient concurrently on 3 or more NGM medications.

- Individual situations, by case or aggregated by prescriber, will be handled in private sessions between the Medical Director and the individual prescriber.

- Documentation related to these activities will be maintained through the Quality Management system of the Center.

The Medical Director also meets with the Administrative Management Team to discuss a variety of issues, including TRR, credentialing, compliance, Action Team information, and hospitalization issues, both state and local.

5. In addition to the above, there is also ongoing monitoring of certain basic issues to assure the safety, health and rights of individuals served of center services. Critical data is reviewed “as it happens” by the RPO, Program Directors, and front-line supervisors.

E. As Needed:

During the year, areas of concern may be identified that are not already being monitored. Specific monitoring may then be developed and implemented to address that particular area. AMT members, Program Directors, or quality improvement teams may coordinate these monitoring activities.

1. Peer Review: A Professional Review Committee member will conduct a clinical review of cases served by a licensed professional employed or contracted by the center on an as needed basis, as recommended by the Executive Director or Medical Director.

2. Compliance Monitoring: The center’s Compliance Officer conducts reviews as needed to monitor for accuracy in documentation and coding and for compliance with requirements and regulations related to billing activities. Results are reviewed by the AMT, which submits recommendations to Program Directors for correction as needed; results are also reviewed by the Quality Improvement Teams. During this process, the records of individuals with a substance abuse disorder on their diagnostic record will be monitored for compliance with Texas Administrative Code 411, Subchapter N - Standards for Services to Persons with Co-Occurring Psychiatric and Substance Use Disorders (COPSD.) The record will be evaluated to ensure that there is an outcome on the individual’s treatment plan that addresses the ongoing issue of the person’s substance abuse disorder and that the outcome is being monitored and addressed by clinical staff.

IX. Review/Revision of the Quality Management Plan

Texoma Community Center’s quality management plan is intended to be a functional and dynamic document that evolves over time. Its effectiveness will be demonstrated by documented improvement in consumer outcomes and by documented improvement in the care and services provided by TCC. Thus, the quality management plan will be reviewed, at least on an annual basis, to determine which areas are in need of revision. At a minimum, the plan will be revised to reflect changes in quality indicators, changes that may have occurred in the QM Department during the past year, to evaluate whether the QM process

and structure has been effective and whether improvement in quality has been demonstrated within TCC. The revision of the Quality Management Plan will result from and reflect this evaluation process and be submitted to the Executive Director and the AMT for approval.

X. Communication

Data collection and QM activities have little effect if the results are not communicated to the relevant persons; therefore, the center continues to enhance its communication systems internally and with stakeholders. Communications need to stress positive aspects of the center as well as opportunities for improvement.

Results of QM activities shall be communicated as follows:

- With the BOT on a monthly basis, including any high profile issues and compliance monitoring.
- With the AMT in the form of a written summary (copies of the full reports of the quality improvement teams; summaries of critical data).
- With the Program Directors in the form of a written summary, verbal description and quarterly updates (copies of the full reports of the quality improvement teams relevant to their areas; summaries of critical data).
- With direct service staff in the form of written or verbal sub-reports with details pertaining to their area alone.
- With the PNAC at least annually (with an emphasis on service outcomes).

XI. Approval/Signatures

______________________________ ______________
Cindy Smith, Quality Management Director Date

______________________________ ______________
Tony Maddox, Executive Director Date

EXHIBIT "A"
EXTERNAL REVIEW PROCESSES
FY2014-2015

WHO/WHAT	Who Receives Results	Responsibility of Plan Development (if needed)
HCS Survey	• Director of IDD Services • AMT • IDD QI Team • Consumer Advisory and Human Rights Committee	Director of IDD Services
ICF-IDD Survey	• Director of IDD Services • AMT • IDD QI Team • Specially Constituted Committee	Director of IDD Services
TxHmL Survey	• Director of IDD Services • AMT • IDD QI Team • Consumer Advisory and Human Rights Committee	Director of IDD Services
IDD Quality Assurance Authority Review	• Director of IDD Services • AMT • IDD QI Team • Consumer Advisory and Human Rights Committee	Director of IDD Services
ECI Survey	• ECI Program Director • AMT	ECI Program Director
Fire Marshall Inspections	• Safety Officer	Relevant Program Directors
Crisis Services Review	• Executive Director; • AMT • MH Action Team	MH Action Team

EXHIBIT "B"
COLLECTION OF CRITICAL DATA –FY 2014-2015

A variety of data is collected to monitor issues related to rights, abuse, safety and health. Below is a description of the data to be collected for FY -2014-2015 and how the data will be obtained. All data is collected, reviewed, and communicated to relevant staff or committees; the data is analyzed for trends and for opportunities for improvement or corrective activities. Critical Data is also reported monthly for all IDD Services via the Critical Incident Reporting System in CARE, which is reviewed by DADS.

Rights

- Rights Restrictions (date/frequency of RPO and/or SCC/HRC review (as applicable) - the RPO shall regularly request and monitor information from service coordinators and case managers regarding any approved rights restrictions that are imposed on individuals served; the RPO shall maintain a list of these restrictions by consumer name and document the dates of the review and approval. The restrictions will, at a minimum, be reviewed on an annual basis.

- Use of Emergency Restraints - the RPO shall track this information by reviewing all Incident Reports and compiling incidents involving such restraints. Incidents shall be reviewed for trends and reports given to relevant program Directors and QM and Action teams.

- Behavior Intervention Plans Utilizing Restraints - the psychologist shall submit this information to the RPO and the SCC/HRC (as applicable) for review and approval.

- Number of complaints/grievances filed - the RPO shall track this information and provide summaries of data to the appropriate QI teams as needed. The information is provided monthly to the AMT and BOT.

Abuse/Neglect

- Number of alleged abuse/neglect reports (including consumer-to-consumer abuse/neglect - this information shall be obtained and tracked by the RPO from Incident Reports and Department of Family and Protective Services Reports, and reported at least monthly to the AMT and BOT.

- Number of substantiated allegations - (same as above).

- Location and type of abuse/neglect reported - (same as above).

- Please see the annual "Plan to Reduce the number of Confirmed Abuse and Neglect Cases" for more details (Attached as Exhibit "C")

Safety

- Building/ Fire Inspections - this information shall be gathered and tracked monthly by the Safety Officer and reviewed and reported monthly by the RPO to the AMT and the BOT.

- Violations/Corrections/Completion Dates - this information shall be gathered and tracked monthly by the Safety Officer, and reviewed by the RPO at least quarterly.
- Number, location and type of safety related incidents - this information shall be obtained from Incident Reports by the RPO and shall be tracked monthly.

Health

- Numbers of serious health-related incidents requiring medical intervention - serious health-related incidents are considered to be those in which an ambulance was called or the person was taken to the emergency room; the cause of such incidents shall be identified whenever possible. The RPO shall obtain this information from Incident Reports and report to the AMT and the BOT on a monthly basis.
- Number of deaths and cause of death - this information is submitted by service coordinators, case managers and/or program Directors to the Quality Management Director. Death reviews are scheduled and conducted according to the guidelines set forth in the Texas Administrative Code.
- Number and type of Medication Errors - the nurses or other relevant staff shall report this information monthly via Incident Reports to the RPO.
- Number and type of diagnosed infectious diseases - this information shall be submitted by the nurses to the RPO who shares the information with the Infectious Disease Committee.

EXHIBIT "C"

FY 2014-2015

PLAN TO REDUCE CONFIRMATIONS OF ABUSE AND NEGLECT

Texoma Community Center, by philosophy, policy and procedure endorses protection of rights of the individuals whom we serve. This includes the right to be free from abuse and neglect. To promote this right within the Center, all employees receive a criminal history clearance, clearance from the DADS Employability Registry and clearance from the Client Abuse and Neglect Reporting System (CANRS) before beginning employment. Also, before any contact is made with individuals served, employees receive extensive rights and abuse and neglect training, including how to identify and report rights and abuse/neglect issues. Employees receive additional abuse/neglect and rights training annually thereafter. When the Center receives an allegation of abuse or neglect or rights violation against an employee or one of its contractors, we review the results of the investigation to determine the need for personnel action, additional training, or changes in policy and procedure.

In addition to the efforts made to assure that employees and contractors have the information and training required to detect and prevent abuse and neglect, the Center also informs and educates the person served regarding their rights. We inform all persons of their rights verbally and in writing at the time of their request for services. These rights are periodically re-reviewed with the person, at a minimum of on an annual basis.

The above practices will continue through FY 2015. A listing of Center efforts to prevent abuse and neglect is listed below.

CRIMINAL HISTORY BACKGROUND CHECKS

Before employment, we require all potential employees to provide consent for the Center to perform the following:

1. Criminal history clearance
2. Motor vehicle register review
3. Drug test screening
4. Employee Misconduct Registry clearance
5. Client Abuse and Neglect Reporting System clearance

The Center also informs the potential employees that they will only be employed if the information received from the criminal history clearance meets the requirements of Chapter 414, subchapter K, of the Rules of the Texas Department of State Health Services (DSHS) and Chapter 4, Subchapter K of the Texas Department of Aging and Disability Services (DADS).

INITIAL TRAINING

Before reporting to their assigned work unit, all new employees, contractors, and

Volunteers must complete initial orientation training. This training includes reading selected Center policies and procedures, reviewing videotapes, and completing training manuals and testing for competency. New employees receive the following training, as applicable, to help them to avoid, identify, and report abuse and neglect of individuals served:

1. Behavior Management (IDD staff only)
2. Cultural Diversity
3. Detecting Illness, Disease, and Abuse
4. Introduction to Mental Health
5. Introduction to Intellectual/Developmental Disabilities
6. Person Directed Planning (IDD staff only)
7. Personal Outcomes (IDD staff only)
8. Prevention and Management of Aggressive Behavior
9. Review of Center Vision, Mission, and Value Statements
10. Review of Client Abuse and Neglect Training
11. Review of Policy and Procedure on Abuse, Neglect, and Exploitation
12. Review of Policy and Procedure on Client Rights
13. Review of Policy and Procedure on Confidentiality and HIPAA
14. Review of video tape on Client Abuse, Neglect, and Exploitation
15. Sensitivity

ONGOING TRAINING

Following the initial training, the Center provides additional training to new and current employees on an ongoing basis. This training is conducted from a Center approved and published staff development curriculum. In addition to regularly scheduled training, refresher training is available as required, needed, or identified. Each training module includes a method to measure competency. This training includes the following:

1. Prevention and Management of Aggressive Behavior
2. Confidentiality
3. Client Rights

4. Prevention and Reporting of Abuse and Neglect, Rights and Confidentiality Violations

5. Vision, Mission Statement, and Values

ACTIONS FOLLOWING INVESTIGATIONS OF ABUSE AND NEGLECT

Following the completion of an investigation of an allegation of abuse or neglect, the Chief Executive Officer or his designee, in consultation with the Center Rights Protection Officer, determines what, if any, changes need to be made to Center policy or procedure. There is also a determination made concerning the need for re-training or additional training for the staff member(s) involved in the allegation. Finally, in confirmed cases, appropriate personnel actions (up to, and including, termination) are determined and implemented.

OTHER MEASURES

- Rights Protection Officer Incident Review and Referral
- Behavior Management Program Review and Approval Process
- Consumer Advisory and Human Rights Committee Review and Approval Process
- Specially Constituted Committee Review and Approval Process
- Rights Protection Officer Advocacy Representation

______________________________________ ________________
Carmen Cooksey, Rights Protection Officer Date

______________________________________ ________________
Tony Maddox, Executive Director Date

EXHIBIT "D"
TEAMS USED IN QUALITY MANAGEMENT ACTIVITIES
FY 2014-2015

Team/ Council/ Committee	Membership	Product/Task/Functions	Meet how often?	Who is responsible?	Who gets results of their work? (Communication lines)
AMT	Executive Director (ED), Chief of Operations (COO), Chief Financial Officer (CFO), Director of Mental Health Services, Director of IDD Services, ECI Program Director, Quality Management Director	Coordinates various aspects of planning operations; responsible for giving strategic direction and guidance. Represents all areas of the center and brings input from stakeholders, including individuals served, family members, employees, local governments, payers, contractors, state agencies/rules, and local community organizations. Core group responsible for developing and tracking center's strategic plan. Primary responsibility for managing risk issues.	3-4 times per month	ED	To Board of Trustees (BOT) To Program Directors
IDD Quality Improvement Team	QM Director, RPO, IDD Services Director, IDD Assistant Director, Other IDD Staff, , Nursing Staff, , QIDP, Residential Coordinator	Reviews Rights, Abuse, Safety and Health (RASH) data and develops a Plan of Action for IDD services. Monitors progress on plan quarterly.	At least once per quarter	Team Chair	Sends report to AMT and IDD Program Director
MH Action Team	COO, Director of MH and Clinical Services, , QM Director, Data Management Coordinator, Nursing Supervisor for MH Services, Clerical Support Supervisor, Data Specialist, Managed Care Specialist, Training Specialist, RPO	Reviews results of QM reviews and RASH data, and develops Plan of Action for the center's MH services. Monitors progress at least monthly.	At least monthly	Team Chair	Sends report to AMT and MH Program Director Communicates relevant information to front line supervisors and staff.
Compliance Committee	Includes Executive Director, Compliance Officer, CFO, Director of Mental Health and Clinical Services	Reviews results of compliance monitoring activities and makes decisions regarding appropriate actions, i.e. paybacks, training to staff, disciplinary actions, procedural changes, etc.	As needed per ED	Compliance Officer	Includes Executive Director, Compliance Officer, CFO, Director of Mental Health Services
Clinical Records Committee	Includes Clinical Records Administrator and a representatives from all sites that maintain clinical records. Includes primarily records clerks but clinical personnel are consulted on a prn basis.	Reviews forms to be used in clinical records. Conducts quantitative chart reviews of program areas annually. Ensures adequate training for records clerks.	At least once per quarter.	Records Administrator	Communicates relevant information to AMT, records clerks, and program Director.
Safety/ Infectious Disease Committee	Staff representing each building/ facility operated by the center; appointed by ED. Includes an RN, the Safety Officer and the Rights Protection Officer.	Monitors buildings for safety and accessibility. Conducts building inspections, arranges for fire marshal inspections, and ensures that emergency drills are conducted and documented. Also, monitors the occurrence of infectious disease and promotes prevention activities. Ensures health inspections are conducted as required. Reviews the success of the Infection Control Plan at least annually. With the guidance of the Medical Director, reviews and revises the Infection Control Plan as needed.	At least once per quarter.	Committee Chair/Safety Officer	AMT and other staff as relevant and pertinent.
Consumer Advisory and Human Rights Committee	Includes staff representing IDD services, family member, consumer, community volunteer, RPO.	Reviews and approves any proposed rights restrictions for individuals served in HCS and TxHmL waiver programs and in GR services as needed; reviews program guidelines; reviews Critical Data; Complaints	At least once per quarter.	Rights Protection Officer	The IDD Program Director Staff involved in proposing or implementing rights restrictions.

Team/ Council/ Committee	Membership	Product/Task/Functions	Meet how often?	Who is responsible?	Who gets results of their work? (Communication lines)
Specially Constituted Committee	Includes staff representing IDD services, family member, consumer, community volunteers, RPO, and at least one member with expertise in behavior management issues	Reviews and approves any proposed rights restrictions for individuals served in the ICF-IDD program; reviews program guidelines; Reviews Critical Data; Complaints	At least annually	Rights Protection Officer	The IDD Program Director Staff involved in proposing or implementing rights restrictions.
Credentialing Committee	Consists of Professional Review Committee and additional licensed staff as needed to include a peer of credentialing applicants.	Reviews credentialing applications for employees and contractors and approves or disapproves credentialed status as a provider with the center.	As needed	Committee Chair	Applicants for credentialed status with the center. Supervisors/ Directors hiring licensed staff.
Utilization Management Committee	Includes Medical Director, Data Management Supervisor, COO, Director of MH and Clinical Services, and Quality Management Director(ED and CFO serve in "ex officio" capacity).	Identifies and analyzes outlier utilization patterns and recommends methods for reducing outliers. Educates clinical decision-makers regarding utilization practices. Will be developing and distributing provider profiles and practice guidelines. Will be defining capacity for service units and assisting the AMT to develop benefit package.	At least once per quarter.	UM Coordinator	AMT. Program Directors. PNAC (provider profiles).
Professional Review Committee	Includes Medical Director, Registered Nurse, LMSW, and LPC/ACP (ED and QM Director serve in "ex officio" capacity).	Reviews certain critical incidents warranting further professional review. Investigates actions by licensed professionals. Provides recommendations regarding quality improvement.	As needed per ED	Team Chair.	ED.
Death Review Committee	Consists of the Professional Review Committee and a non-affiliated member from the community.	Reviews deaths in accordance with State guidelines.	As needed.	Executive Director	State
Planning and Network Advisory Committee	Includes consumer/family representation for MH and IDD Services, Non-affiliated community members		At least once per quarter.	Rights Protection Officer	Board of Trustees AMT

TEXOMA COMMUNITY CENTER
QUALITY MANAGEMENT OVERSIGHT